

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1928	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/10/2010
NAME OF PROVIDER OR SUPPLIER TREVECCA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 329 MURFREESBORO RD NASHVILLE, TN 37210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the annual Licensure survey conducted on February 10, 2010, at Trevecca Health Care Center, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.		N 001		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

ADMINISTRATOR

(X6) DATE

2-25-'10